

Exhibit C



Deposition of:
Stephen B. Levine , MD

September 10, 2021

In the Matter of:
Kadel, et al vs. Folwell

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

~~~~~

MAXWELL KADEL, et al.,

Plaintiffs,

vs. Case No. 1:19-cv-272-LCB-LPA

DALE FOLWELL, in his official  
capacity as State Treasurer of  
North Carolina, et al.,

Defendants.

~~~~~

Video Deposition of
STEPHEN B. LEVINE, M.D.

September 10, 2021
9:05 a.m.

Taken at:
Veritext Legal Solutions
1100 Superior Avenue
Cleveland, Ohio

Tracy Morse, RPR

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1 Q. Okay. And so then were there any
2 external grants to research and publish about
3 the treatment of children or adolescents --

4 A. No.

5 Q. -- with gender dysphoria?

6 Okay. Is that a, "No," when I included
7 the, "Gender dysphoria," as well?

8 A. That is a, no.

9 Q. Okay. Thank you. Okay. So on
10 page 3 of your report -- actually, I'm sorry.
11 It's going to be the bottom of page 4 and to
12 the top of page 5. Your report lists your
13 experience as an expert witness, which we
14 talked about a little bit earlier. I just --
15 I'm wondering if you would confirm this is not
16 an exhaustive list of your experience as an
17 expert witness either via deposition or report.

18 A. I wouldn't want to testify that
19 this is absolutely complete, given the fact
20 that I don't keep a list compiled. This is
21 kind of compiled retrospectively from memory
22 and documents. And so this is the best I could
23 have done on April of 2021 --

24 Q. Understood. Thank you. So --

25 A. -- you might find something else.

1 Q. Was it --

2 A. -- in a commercial building where
3 our clinic was. It was just, you know, a
4 conference room in our clinic.

5 Q. And that was within -- was that
6 within a business --

7 A. It was --

8 Q. -- a psychiatric practice?

9 A. I'm sorry. I interrupted you.

10 It was within The Center For Marital
11 Health, which was a business that I and two
12 other people started and owned and ran. And in
13 that business, we continued the same kind of
14 work we did with the University minus the large
15 number of trainees.

16 Q. You mentioned that after '93, you
17 were not being paid by the University. Were
18 you providing your clinical psychiatric
19 professorship gratuitously?

20 A. Meaning without pay? Yes.

21 Q. Okay. Do you know if, after you
22 moved the clinic away from Case Western
23 Reserve, if Case Western Reserve University
24 Medical School created a separate gender
25 identity clinic?

1 A. Years later they did --

2 Q. Oh, sorry.

3 A. -- I would say, they created a
4 separate clinic perhaps in 2017, 2016.

5 Q. Do you know the name of that
6 clinic?

7 A. I don't think it's in the
8 department of psychiatry. I think it's in the
9 department of pediatrics. And the answer to
10 your question is, no.

11 Q. Does The LGBTQ and Gender Care
12 Program sound familiar?

13 A. No.

14 Q. But have you -- sorry. Have you
15 evaluated any patients through that separate
16 clinic that Case Western Reserve has?

17 A. No. Much to my dismay, that clinic
18 was formed and maintained without any input
19 from me, who I thought was one of the experts
20 in the field.

21 Q. Do you know if they have
22 psychiatrists, within that clinic?

23 A. I -- I'm not knowledgeable about
24 the composition of that clinic. There is a
25 very strong liaison between our department of

1 What do you mean by, "This era"?

2 A. Before 1993.

3 Q. Okay. And what do you mean by,
4 "Occasional"?

5 A. I would say that 95 percent of the
6 patients that we saw were 16 and 17, 18 and up.
7 We could debate what the word, "Child," means,
8 but to me an 11-year-old is a child, even
9 a 13-year-old is a child, especially when my
10 children were 13. And so we -- in the first
11 twenty years, transgender issues were primarily
12 an older teenager and adult, mostly adult
13 issues. In recent years, I would say, 12, 15
14 years, the number of adolescents appearing in
15 gender clinics at our place and everywhere as
16 far as I can see has increased exponentially,
17 especially the number of teenage girls who are
18 declaring themselves trans boys.

19 Q. So how many -- sorry. So the first
20 twenty or so years, you said approximately 5
21 percent of all patients were children.

22 A. Were younger -- on the younger end
23 of the spectrum --

24 Q. Right.

25 A. -- yes.

1 it, you see? But at this moment -- this week,
2 I have one patient that I see weekly, who is a
3 transgender teen. My staff -- if I can be
4 presumptuous to call them, "My staff" -- our
5 staff sees more.

6 Q. And thinking about the last year,
7 approximately how many adult patients did you
8 see -- and let's use your framing of,
9 "Regular." So that could be one, for one
10 followup visit or that could be for more -- how
11 many adult patients did you see for treatment
12 of gender dysphoria?

13 A. Approximately six.

14 Q. And using that same framing of,
15 "Regular," how many children, so under age 11?

16 A. In the last year?

17 Q. Yes, yes. In the last year.

18 A. Zero.

19 Q. How many adolescents in regular
20 treatment for gender dysphoria would you
21 approximate you've seen in the last five years
22 individually, exclusive of your supervision of
23 other clinicians?

24 A. If you ask me the question in the
25 last year, I would have told you five or six,

1 but since you ask it as a five-year period, I'm
2 at a loss to tell you whether it's twelve or
3 fifteen. I --

4 Q. An approximate is fine. Thank you.

5 A. -- let's just say a dozen with an
6 asterisk, very approximate.

7 Q. And jumping a little bit more in
8 terms of time. How about the last ten years?

9 A. Again, using the same asterisk, I
10 would say, double it.

11 Q. Okay. And you said zero people
12 under age 11, so children this last year. What
13 about in the last five years?

14 A. Oh, two years ago, we had this
15 charming little 6-year-old. One of my
16 colleagues specializes in children and I get to
17 hear about these cases. Occasionally I get to
18 meet the parents, but I personally have not
19 delivered a psychotherapeutic care or
20 evaluation directly of a child with the
21 exception of this one person that I was
22 involved with.

23 Q. And that was this last year, you
24 said?

25 A. That was -- I think it was probably

1 two, two and a half years ago.

2 Q. Oh, okay. And what kind of
3 treatment -- I should say, have you referred
4 any of those adolescent patients for additional
5 treatment, besides psychotherapy, for the
6 treatment of gender dysphoria?

7 A. Yes.

8 Q. And what kinds of treatment have
9 you referred them for?

10 A. For endocrine treatment.

11 Q. Okay. And approximately what
12 percentage of those adolescent patients have
13 you referred for endocrine treatment?

14 A. Give me the timeframe of that
15 question, please.

16 Q. Sure. So you said a few moments
17 ago, in the last five years, you saw maybe,
18 asterisk, 12 to 15 adolescent individually
19 yourself. Of those 12 to 15, what would be the
20 approximate percentage you referred for
21 endocrine treatment?

22 A. I'm hesitating to answer the
23 question, because some of those children have
24 been taking testosterone or estrogen
25 surreptitiously from their parents. And while

1 I didn't refer them for the treatment, I was
2 seeing them while they were taking the
3 treatment. So if we're only talking about
4 adolescent -- referrals of adolescents for
5 hormones, I would say a very small percentage
6 of those, say, I guess you would say 10
7 percent.

8 Q. Fair enough. Have you had yourself
9 individually as a clinician, have you had any
10 non-transgender children who you have made a
11 referral for endocrine treatments related to
12 other conditions?

13 A. No.

14 Q. Okay. So then zooming out 30,000
15 foot view of your 48-year career now, would you
16 say overall, you have provided treatment --
17 that is, psychiatric treatment -- to mostly
18 adults experiencing gender dysphoria, gender
19 identity issues?

20 MR. KNEPPER: Objection, form.

21 A. I would say that throughout my
22 career, we should divide my career into the
23 first twenty years where mostly adults were
24 seen by our team and myself. And then we ought
25 to talk about the last ten or fifteen years

1 where the number of adults has diminished and
2 the number of adolescents has increased
3 dramatically.

4 Q. Okay. Thank you. So as a part of
5 your private practice, do you write letters of
6 authorization for endocrine treatments?

7 A. Yes.

8 Q. And do you write letters of
9 authorization for gender affirming surgeries?

10 A. I have. I have not recently,
11 because most of my patients are 13 or 15 or 16,
12 you know.

13 Q. Okay. And I'm sorry. Just by,
14 "Recent," when was the last time you wrote a
15 letter of authorization for a gender affirming
16 surgery for an adult?

17 A. Probably twelve months ago.

18 Q. Okay. And over the course of your
19 career focusing on your treatment of adults
20 experiencing gender identity issues, for what
21 percentage of those patients would you estimate
22 you wrote a letter of authorization for gender
23 affirming surgery for?

24 MR. KNEPPER: Objection, form.

25 A. Again, I would like to put an

1 asterisk to whatever I answer this question as.
2 I have not kept track of those figures. I have
3 written -- I've written or cosigned letters for
4 hormone treatments and for gender confirming
5 surgeries for many people. There were more
6 people in the '70s and '80s than in recent
7 decades. In part as a reflection of my own
8 evolution of understanding of these problems
9 and in part it's a reflection of the demography
10 of patients who are coming to see me. I really
11 would not like to answer that question, only
12 because I don't know if the word, "Fifteen," or
13 the word, "Twenty-five," or the word,
14 "Thirty-five," is more accurate --

15 Q. Understood.

16 A. -- but I can tell you, I have
17 written letters, especially in the early years,
18 for the things that you're making reference to.

19 - - - - -

20 (Thereupon, Deposition Exhibit 2,
21 12/21/2020 Zoom Deposition of
22 Stephen B. Levine, M.D., was marked
23 for purposes of identification.)

24 - - - - -

25 Q. Okay. For the record, I'm showing

1 Q. Do you think as a general matter
2 that it's good for patients who come to DELR
3 for services related to gender dysphoria to be
4 able to have insurance coverage of that care?

5 MR. KNEPPER: Objection, form.
6 Beyond the scope.

7 A. Well, the people who come to DELR
8 are generally coming for evaluation and
9 psychotherapy services. And I believe it's
10 very important that people have access to
11 mental health care and that mental health care
12 for many of our patients are not wealthy,
13 affluent people. And the fees that even
14 masters prepared people charge can become
15 prohibitive. And so I think it's a very nice
16 idea, the psychiatric services, mental health
17 services evaluation and ongoing treatments,
18 with or without medication, it would be nice to
19 be able to cover those things, yes. I think
20 that's a long answer, yes.

21 Q. Understood. And thinking about the
22 treatment that you refer patients out for, the
23 endocrine treatments in particular, do you
24 think it is generally good if you provide
25 authorization for that treatment that the

1 patient be able to afford it?

2 MR. KNEPPER: Objection, form.

3 A. May I say, of course?

4 Q. You may. You may say anything you
5 would like.

6 A. Of course.

7 Q. Thank you. Well, anything you
8 would like within reason.

9 If you make a letter of authorization for
10 a patient for the treatment of gender dysphoria
11 specifically related to a surgical treatment,
12 do you think it is good that they be able to
13 access that treatment that you've authorized?

14 MR. KNEPPER: Objection, form.

15 A. Not to be cagey, I want to talk
16 about one word you just used in that sentence.
17 I need you to understand that historically in
18 our clinic for those 47 years, our clinics
19 for 47 years, we are not in the business and we
20 have never been in the business of recommending
21 surgery or recommending hormones. We recommend
22 a continued evaluation so that we -- the person
23 can make up their mind how to proceed.

24 It is not our knowledge base to know
25 who's going to do better and who's going to do

1 worse and who is not going to have any
2 difference at all with hormones or with
3 surgery. So what we do is we say, we will
4 write a letter of support for endocrine
5 treatment or for hormones if this is what you
6 want. And we say what our concerns are. We
7 tell the endocrinologist and we tell the
8 surgeon what our concerns are and that we
9 see -- we have reservations about this, and
10 these are our reservations, but the patient has
11 decided this is what he or she wants to do.

12 And so we write a letter of support, but
13 I don't -- every time you use the word,
14 "Recommendation," there's part of me that wants
15 to say, no, we do not recommend. We have never
16 recommended. We have not had the knowledge
17 base. We have not had the clinical experience
18 and the knowledge base to say, I'm a doctor. I
19 know this field. This is what I recommend to
20 make you better. We do not talk that way. We
21 do not think that way. And so I may want to
22 always put an asterisk to any sentence that you
23 use the word, "Recommend." I need you to
24 understand that that's where I'm coming from.

25 MR. CHARLES: Thank you,

1 Dr. Levine.

2 Excuse me just a moment. Can you read
3 back my question. I don't recall if I used,
4 "Recommend." I thought I used,
5 "Authorization." I just want to make sure.

6 (Record was read.)

7 MR. CHARLES: If we could just go
8 off the record for a second.

9 VIDEOGRAPHER: Off the record 10:52.

10 (Discussion held off the record.)

11 VIDEOGRAPHER: On the record 10:53.

12 BY MR. CHARLES:

13 Q. Okay. Thank you for that
14 clarification, Dr. Levine. I'll be more
15 careful about using terminology more close to,
16 "Authorization," rather than, "Recommendation,"
17 and I understand your distinction in your
18 practice. So do you, though, think it's good,
19 if you are authorizing a treatment, a patient
20 has said, This is the treatment I would like,
21 and you have done an evaluation and determined
22 that you will write, as you said, a letter of
23 support, do you then, as a practitioner, think
24 it's good that they can access it, that they
25 can afford it?

1 concept of agency and being a doctor, I think
2 is different than the implication of your
3 question.

4 Q. Is the worrisomeness for a
5 patient's future health, is that a reason to
6 deny all medical care for gender dysphoria?

7 A. Absolutely not.

8 Q. Dr. Levine, I'd like to return back
9 to, I believe it's Exhibit 2, the Claire
10 deposition. And please, if you would turn to
11 page 156.

12 A. I'm sorry. 150 what?

13 Q. Page 156. And beginning at line 10
14 on page 156, Dr. Levine, I'll read it, if
15 you'll just follow along, please.

16 Question: "Are you aware that this case
17 concerns an insurance exclusion that is
18 categorical at preventing" --

19 Skipping to line 15.

20 "-- hormones and surgery as a treatment
21 for gender dysphoria?"

22 Answer: "I am aware that your plaintiffs
23 are suing to get coverage for -- that is not
24 provided by their particular insurance. I am
25 aware of that."

1 demonstrate their efficacy. This is the
2 problem.

3 This is the essence of the problem. This
4 is, I think the essence of my testimony with
5 you today. It's not whether I personally as a
6 doctor would like this patient to have
7 insurance to cover their hormones. It's about,
8 is this the right thing to do for this person
9 and can I help the person see clearly what the
10 dangers are and what the benefits are. That's
11 the issue for a doctor, for Stephen Levine as a
12 doctor. I hope that's a cogent answer --

13 Q. It is --

14 A. -- to your question.

15 Q. -- it is cogent. Thank you.

16 Given all of that, is that -- so you just
17 explained, testified that there are
18 complications, some lack of -- and I'm
19 summarizing here, so I will confirm that this
20 is an accurate summary of what you just shared,
21 but I can't possibly repeat all of that. Given
22 all of those concerns that you have, is that a
23 reason to deny all medical interventions to
24 people with gender dysphoria?

25 MR. KNEPPER: Objection, form.

1 A. No, but that's not -- that's a
2 separate question about insurance.

3 Q. Yes, it is a separate question. So
4 now I'm asking: Are those concerns you raised
5 justifications in your mind for denying medical
6 interventions to all people with gender
7 dysphoria?

8 MR. KNEPPER: Objection, form.

9 A. You know, I'm not advocating
10 denying endocrine treatment or surgical
11 treatment. I'm just saying that we as a
12 medical profession need to walk the walk that
13 we talk. We say as a principle of ethics that
14 our interventions should be based upon the best
15 current knowledge, it should be based on
16 science. It should not be based on politics.
17 It should not be based on fashion. It should
18 not be based on civil rights considerations.
19 They should be based on the kinds of studies
20 that I just described to you with predetermined
21 outcome majors that are agreed upon --

22 Q. Sorry?

23 A. -- period.

24 Q. I was --

25 A. I forgot to put the period.

1 Q. That's okay. Did you just say,
2 Dr. Levine, you're not an expert in health
3 insurance?

4 A. I am not an expert in health
5 insurance.

6 Q. Okay. Or what insurance should or
7 should not cover?

8 A. Yes.

9 Q. Do you recall what the insurance
10 billing code typically is for psychotherapy for
11 gender dysphoria? I know it's been a long time
12 since you've accepted commercial insurance, so
13 I'm not sure if the billing codes are the same,
14 but do you recall --

15 A. The billing code is 90837.

16 Q. Okay. Is there a code that you're
17 familiar with that is F64.0?

18 A. That's not a billing -- that's
19 diagnostic code --

20 Q. Thank you.

21 A. -- there's a separate code for
22 diagnosis and a separate code for procedure.

23 Q. I see. So F64.0 is a diagnostic
24 code?

25 A. Yes.

1 VIDEOGRAPHER: Off the record 11:26.

2 (Recess taken.)

3 VIDEOGRAPHER: On the record 11:31.

4 BY MR. CHARLES:

5 Q. Okay. Dr. Levine, in your report,
6 you stated that you had not met with any of the
7 plaintiffs in this case, correct?

8 A. Yes.

9 Q. Okay. And you have not interviewed
10 any of the plaintiffs in this case, correct?

11 A. Correct.

12 Q. And so you are not offering any
13 opinions about the plaintiffs in this case,
14 correct?

15 A. Correct.

16 Q. Okay. And that would include the
17 veracity of their experiences of gender
18 dysphoria, correct?

19 A. Yes, correct.

20 Q. And that would not include the
21 accuracy of their gender dysphoria diagnoses,
22 correct?

23 A. Correct.

24 Q. Okay. You're not offering any
25 opinions about their mental health histories?

1 A. Correct.

2 Q. Nor any of the affects of the
3 gender affirming treatment they may have
4 received?

5 A. Correct.

6 Q. Okay. Thank you. Let's return to
7 your report. I don't know if you have that --

8 A. My report?

9 Q. Yes. You can put away that
10 document in your hand.

11 So if you would, please, turn to page 6
12 of your report.

13 Okay. So on page 6, paragraph a. at the
14 bottom of the page there, Dr. Levine. The
15 report states that this is one of the opinions
16 you're offering, which is, "Sex as defined by
17 biology and reproductive function cannot be
18 changed. While hormonal and surgical
19 procedures may enable some individuals to
20 'pass' as the opposite gender during some or
21 all of their lives, such procedures carry with
22 them physical, psychological, and social risks,
23 and no procedures can enable an individual to
24 perform the reproductive role of the opposite
25 sex." Did I read that correctly?

1 methodology and are capable of critically
2 reviewing the literature. So your statement is
3 true on the most superficial level, but is
4 totally incorrect when it comes to scientific
5 standards of care for issuing guidelines for
6 the medical profession. So I don't know how to
7 answer the question. On the surface, the
8 answer is, yes. And underneath the surface,
9 the answer is, no.

10 Q. So the International Journal For
11 Transgender Health is still a peer-reviewed
12 source, though, right?

13 A. It's peer reviewed by people who
14 make their living supporting transgender care.

15 Q. But it's still peer reviewed,
16 right?

17 A. It's peer reviewed --

18 Q. And as for your --

19 A. -- I think it's peer reviewed.

20 Q. Okay. Understood. And as for your
21 more conservative approach, can you cite to any
22 studies or research that resulted in better
23 outcomes than people who adhere strictly to the
24 WPATH standards of care version 7?

25 A. No. This is part of the problem in

1 evaluation leading to a therapeutic process, it
2 seems prudent, given the fact that we are
3 changing people's bodies, especially teenagers'
4 bodies, and they are not of developmental
5 sophistication yet that court systems or at
6 least one court system thinks they're certainly
7 too young to make these life-altering
8 decisions. So people in SEGM are biased in the
9 direction of being conservative and providing
10 psychotherapeutic evaluations of the child, of
11 the teenager and of their parents, of their
12 family systems to see if we can find a way to
13 help them be informed about what is going --
14 what they think they want to do in their
15 future.

16 Q. And so when you provide letters of
17 authorization for hormones or for surgery, do
18 you do so in accordance with the WPATH
19 standards of care?

20 A. Yes. That is the standard, to
21 provide a letter of recommendation.

22 Q. Okay. So turning back to your
23 report, Dr. Levine. You can go ahead and put
24 away the trial transcript there.

25 A. I'm sorry. Did you say, "Turning

1 Q. Okay. So is a, "Hypothesis," an
2 idea about why something happens, but doesn't
3 provide evidence for why something is
4 happening?

5 MR. KNEPPER: Objection, form.

6 A. A, "Hypothesis," generates the
7 pursuit of evidence.

8 Q. Has social contagion as an
9 explanation for increased cases of gender
10 dysphoria been scientifically proven yet?

11 A. No. But when you seek -- when you
12 see -- actually see patients and talk to them
13 about their friends and hear about the
14 influence of the Internet and the gurus on the
15 Internet who tell 13 and 12-year-old children
16 who are concerned about menses or concerned
17 about breast development or concerned about
18 their bodies changing and then they're told
19 that they're transsexual by somebody that
20 they've never met that they talked to on the
21 Internet, that would be social contagion or
22 social education.

23 Or when you hear about a friend who
24 declares themselves trans and then your patient
25 six months later declares themselves trans, you

1 wonder about the -- the interpersonal,
2 psychological link between best friends in
3 young puberty, young years of puberty and how
4 one can identify with one's friends and that
5 would be a social contagion. Those are 3the
6 kinds of ideas that people like me get when we
7 sit with people week after week talking about
8 their lives. You see, that's not science.

9 But that is clinician and this is the
10 kind of thing that leads to intuition, clinical
11 intuition and that's the source of the
12 generation of the hypothesis. But we think as
13 clinicians, when we hear -- I mean, I don't
14 think I've ever seen a teenager trans person
15 who hasn't been heavily involved and influenced
16 by the Internet, for example, but I have not
17 done studies to document that in a way that
18 would be scientifically acceptable. There are
19 other people who have.

20 And I doubt very much if you'll ever find
21 a clinician on any side of this issue, you see,
22 who would say, oh, no most of my patients have
23 never talked to anyone on the Internet about
24 transgender. The Internet is just part of life
25 today and -- but transgender teenagers spend

1 hours and hours of their time getting counseled
2 or participating with the virtual trans
3 community. That's a hypothesis.

4 Q. So no scientific citation?

5 A. When we use the word, "Scientific,"
6 in the best sense, yes, the answer to your
7 question is, no scientific.

8 Q. Okay. No studies of citations you
9 can point to today to support that hypothesis?

10 A. Oh, I think Lisa Littman's studies
11 are in the literature and/or in press that
12 documents this.

13 - - - - -

14 (Thereupon, Deposition Exhibit 7,
15 "Correction: Parent reports of
16 adolescents and young adults
17 perceived to show signs of a rapid
18 onset of gender dysphoria," Article,
19 was marked for purposes of
20 identification.)

21 - - - - -

22 Q. Okay. For the record, please note
23 I'm showing to Dr. Levine what has been marked
24 as Exhibit 7. "Correction: Parent reports of
25 adolescents and young adults perceived to show

1 signs of a rapid onset of gender dysphoria," by
2 Lisa Littman published March 19, 2019. Have
3 you seen this material before, Dr. Levine?

4 A. I've seen of it. I don't think
5 I've read it.

6 Q. Okay. Were you aware that the Lisa
7 Littman article had to be withdrawn, corrected
8 and republished?

9 A. Yes.

10 Q. Okay. And were you aware that the
11 initial article was based on a survey of
12 parents --

13 A. Yes.

14 Q. -- of purportedly transgender
15 children and the parents were recorded -- I'm
16 sorry. Let me start over. Were you aware that
17 the Littman article was based on a survey of
18 parents who were recruited through some parent
19 groups?

20 MR. KNEPPER: Objection, form.

21 A. I knew it was a survey of parents.

22 Q. Okay. And did you know there were
23 no report-outs from the young adults of those
24 parents in the article?

25 A. It was a report of parents'

1 transitioning. However, it is...important to
2 note that there are other survey items where
3 the parent would have direct access to
4 information about their child and that those
5 answers reflect items that can be directly
6 observed." Did I read that correctly?

7 A. Yes, you did.

8 Q. All right. Your report also cites
9 as support for the social contagion hypothesis
10 to an article from Medscape.com written by
11 Becky McCall and Lisa Nainggolan as support for
12 the social contagion theory. Is that correct?
13 I'm sorry. It's not going to be on this
14 article, Doctor.

15 A. I don't know that article.

16 Q. Okay.

17 A. You haven't asked me a question
18 about this. Did I misunderstand something?

19 Q. No, no. Sorry. We're just --

20 A. You haven't asked my opinions about
21 that, yeah.

22 - - - - -

23 (Thereupon, Deposition Exhibit 8,
24 "Transgender Teens: Is the Tide
25 Starting To Turn?" Article, was

1 marked for purposes of
2 identification.)

3 - - - - -

4 Q. Yeah. So, for the record, I'm
5 showing Dr. Levine what has been marked as
6 Exhibit 8. "Transgender Teens: Is the Tide
7 Starting To Turn?" by Becky McCall and Lisa
8 Nainggolan, April 26, 2021. Dr. Levine, you
9 said you have not reviewed this article before?

10 A. Which one are you referring to?

11 Q. I'm sorry. That one to your left.

12 A. This?

13 Q. Yes. Take your time.

14 A. Have I reviewed it, no. You know,
15 I've seen the picture of Keira Bell. I've seen
16 news reports of this in the past, but they were
17 just news reports, yeah.

18 Q. Do you know if either of the
19 authors of this article is a scientist?

20 A. I have no idea.

21 Q. Okay. Or a psychiatrist?

22 A. (Indicating.)

23 Q. I'm sorry. Could you make your
24 responses verbal? I'm forgetting.

25 A. I have no idea.

1 Q. Okay. Thank you. Have either of
2 them ever treated transgender children or
3 adolescents?

4 A. I would have no idea.

5 Q. Okay. To your knowledge, is the
6 information provided on Medscape.CA subject to
7 peer review?

8 A. I don't know how Medscape works.
9 I've heard there have been retractions, but I
10 don't know how their peer reviewed is made.
11 Perhaps people write in that, This is
12 ridiculous what you've been teaching or what
13 you've been saying, but whether they're peer
14 reviewed or not, I have no idea.

15 Q. So you probably -- I'm sorry. So
16 do you know if this article has been published
17 in a peer-reviewed journal to your knowledge?

18 A. "Transgender teens: Is the
19 Tides" -- that article?

20 Q. Yes.

21 A. I don't know. I don't know this
22 article. I don't know where it's from.

23 Q. Okay. So your report includes a
24 quotation from this article. "The vast
25 majority of youth now presenting with gender

1 multi-continental set of observations from
2 Europe, from Australia, from North America --

3 Q. Okay.

4 A. -- it almost doesn't even need
5 citations it's so clinically apparent.

6 Q. Okay. But there's no citation in
7 your report?

8 A. In my report, yes.

9 Q. Okay. So on page 18, going back to
10 your report, at the bottom of page 18, you use
11 a term, "Transgender Treatment Industry." Is
12 this the first time you have used this term?

13 A. In this report?

14 Q. No.

15 A. You mean, did I ever use it in
16 another report?

17 Q. Yeah, yeah.

18 A. I'm not sure. If this is -- if
19 it's not the first, it might be the second.

20 Q. And where did the term originate?

21 A. I think it -- the term originated
22 from Dwight Eisenhower at the end of his --
23 when he was leaving the presidency in 1952, he
24 warned the people about the military industrial
25 complex and that there was a very comfortable

1 the methods we made reference to before, the
2 efficacy of the treatment and the downsides of
3 the treatment. But because WPATH is an
4 advocacy organization and the scientific
5 establishment of the efficacy of their
6 treatments are not important to them, what they
7 are doing is teaching young mental health
8 professionals and medical professionals as a
9 whole what their ideology is. They say it's
10 scientifically established.

11 I'm here to tell you to the extent that I
12 understand science, it is not scientifically
13 established. In a sense, there is an industry
14 that has different elements that feed each
15 other; that's the transgender treatment
16 industry. I think if we put our heads
17 together, we could find another term.

18 Q. So did you coin that phrase then?

19 A. No --

20 Q. Okay.

21 A. -- no.

22 Q. Have you seen it used before in any
23 peer-reviewed articles?

24 A. Not in a peer-reviewed article.
25 I've seen it used in these kind of expert

1 opinion -- (Indicating.)

2 Q. Okay.

3 A. -- I would -- you know, if I had
4 time and I had a committee of people, I -- I
5 would probably find a different term for it.
6 But I don't mean it in a disparaging way. I
7 mean that this is a group of compassionate
8 people trying to help other people who actually
9 believe that the science has established the
10 best practices when in fact they're not well
11 informed.

12 Q. Do you need a sip of water after
13 that?

14 A. No. I'm just a long-winded guy.

15 I want to add, if I may, that we should
16 make a distinction between education and
17 indoctrination. Education can be based on
18 science. Indoctrination is based on preferred
19 beliefs that, if you allow me to use this term
20 again. The transgender treatment industry is
21 heavy on indoctrination and has declared, if
22 you look at the standards of care, if you don't
23 believe these systems, you're not a
24 competent -- you're not competent to take care
25 of people. That of course is the height of

1 A. No. Their gender dysphoria may be
2 a product, you see, of these other things. For
3 example, if you have someone who has been
4 sexually abused by her stepfather and becomes a
5 trans person in adolescents, we want to talk
6 about the sexual abuse and the process between
7 that person and what fears for the present and
8 the future that has caused the child. And
9 we're not attacking their trans identity.
10 We're trying to help them understand where they
11 came from and what they're coping with and why
12 they're so fearful or so distressed by their
13 body changing.

14 Q. And their gender dysphoria could be
15 separate and apart from that traumatic
16 experience?

17 A. Theoretically it could be, yes.

18 Q. And if it persisted sufficiently
19 enough, you would consider a letter of
20 authorization for --

21 A. Yes.

22 Q. -- hormones?

23 A. Yes.

24 MR. KNEPPER: Objection, form.

25 Q. Okay. If you would, please, turn

1 A. That is correct. And may I add
2 that it's very, very difficult to understand.
3 The natural question would be, how do you
4 compare the general population with the trans
5 people who did not have surgery with the trans
6 people who did have surgery.

7 Q. Thank you, Dr. Levine. That's not
8 my question, though. I just wanted to confirm
9 that was not the control group. You mentioned
10 this study later in your report, page 66
11 beginning at paragraph 74. Do you see that?

12 A. Um-hum.

13 Q. Okay. And basically that -- well,
14 here, let me point you exactly. The sentence
15 starts with, "Similarly," about halfway down
16 the page, third sentence of that paragraph.

17 A. Um-hum.

18 Q. And, as you mentioned, you cite the
19 Dhejne study and I believe -- or I should ask:
20 Is the Denmark study you're referencing the
21 study directly after it --

22 A. The Simonsen study.

23 Q. -- the Simonsen study?

24 A. Yes.

25 Q. Okay. So beginning with the Dhejne

1 study, do you think because that study showed
2 that some people committed suicide after gender
3 affirming surgery that no patient should be
4 able to access gender affirming surgery?

5 MR. KNEPPER: Objection, form.

6 A. That would be illogical.

7 Q. Okay. Dr. Levine, I understand you
8 said that would be illogical, but just to be
9 clear. You're not recommending -- sorry. I'm
10 not using that word. You're not saying that
11 the fact that some people commit suicide
12 following gender affirming surgery means that
13 there should be a ban on access to that
14 surgery. Is that right?

15 A. Not for that reason, no.

16 MR. KNEPPER: Objection, form.

17 Q. Not for that reason. Okay. Are
18 you recommending that there would be bans on
19 gender affirming surgery for any reason?

20 A. I think there are -- you know, I
21 think most prudent people in this field, just
22 to use the example of what you read out loud
23 about the Finland study, a case-by-case basis.
24 That's how doctor need to decide things, but
25 there are many, many reasons to be cautious

1 fashion and to be very hesitant about going
2 forward.

3 Q. But you're not recommending total
4 bans on gender affirming surgery?

5 A. I'm not recommending total bans.
6 I'm aware of the individual circumstances of
7 individual people's lives and their commitment
8 to transgender living. And I don't want to be
9 draconian about this. I want to be
10 compassionate about this.

11 Q. I understand. I appreciate that.
12 I just want to make sure I'm understanding you
13 correctly.

14 - - - - -

15 (Thereupon, Deposition Exhibit 12,
16 "Long-Term Follow-Up of Transsexual
17 Persons Undergoing Sex Reassignment
18 Surgery: Cohort Study in Sweden,"
19 Article, was marked for purposes of
20 identification.)

21 - - - - -

22 Q. So for the record, I'm presenting
23 to Dr. Levine what has been marked as
24 Exhibit 12. "Long-Term Follow-Up of
25 Transsexual Persons Undergoing Sex Reassignment

1 For the 22nd time today, did I read that
2 correctly?

3 A. It's the 23rd time.

4 Q. Oh, okay.

5 A. Yes.

6 Q. I was hoping you weren't counting,
7 but, okay. Did you testify earlier today that
8 the limitation of the Dhejne study is that the
9 controls were not transgender persons who had
10 not undergone gender affirming surgery?

11 A. Yes.

12 MR. KNEPPER: Objection, form.

13 Q. Okay. You can set that aside,
14 Dr. Levine.

15 - - - - -

16 (Thereupon, Deposition Exhibit 13,
17 2017 "On Gender Dysphoria," Booklet
18 From Department of Clinical
19 Neuroscience, Karolinska Institutet,
20 Stockholm, Sweden, was marked for
21 purposes of identification.)

22 - - - - -

23 Q. For the record, Dr. Levine has an
24 exhibit that has been marked as Exhibit 13.
25 "On Gender Dysphoria," by Cecilia Dhejne from

1 ideation in transgender people.

2 A. Well, you know about the
3 Branstrom-Pachankis study and the criticism of
4 the study --

5 Q. But I'm not talking about the
6 study.

7 A. -- and part of the study
8 demonstrated that it increased suicidal
9 ideation and attempts in the first two and a
10 half years after surgery, especially in the
11 first year --

12 Q. Right. Is your testimony --

13 A. -- so I'm not testifying that. I
14 thought you were asking me about this, which I
15 need to comment on, because this is not an
16 accurate depiction of my statement in the
17 reference. (Indicating.)

18 Q. Well, that's not what I'm asking
19 about, Dr. Levine.

20 A. Well, you're reading this and I'm
21 misquoted here. So I don't want you to imply
22 that she is accurately representing my views,
23 because I did not say that gender affirming
24 treatment in general should be stopped. I've
25 never said that. This is an article about

1 at different times have reported that in the
2 large majority of patients, absent a
3 substantial intervention such as social
4 transition and/or hormone therapy, gender
5 dysphoria does not," continue, "through
6 puberty."

7 So there are some children who persist in
8 their asserted gender identity through puberty,
9 correct?

10 MR. KNEPPER: Objection, form.

11 A. Correct.

12 Q. And some who persist in wanting to
13 transition via medical treatments?

14 MR. KNEPPER: Objection, form.

15 A. Yes. Some of the children have
16 learned about medical treatments somewhere
17 along the line and they feel instantly that
18 this is for them.

19 Q. And then looking at paragraph 56,
20 which is on page 41, so just the very next page
21 on the bottom, the second sentence in that
22 paragraph. "I observe an increasingly vocal
23 online community of young women who have
24 reclaimed a female identity after claiming a
25 male...identity at some point during their teen

1 transgender people is individual based, right?

2 A. Well, it's both --

3 MR. KNEPPER: Objection, form.

4 A. -- yes, that's partially true. And
5 ideally that's true, but it's obviously not
6 entirely true. It's why we're here, is it's
7 categorically based.

8 Q. Let me rephrase that. You design
9 treatment for your patients based on what that
10 patient in front of you, what they need, what
11 they want, what you determine -- sorry. Not
12 what you determine, but what you might
13 authorize?

14 MR. KNEPPER: Objection, form.

15 A. What the patient and I discern
16 together.

17 Q. Thank you. Okay. Let's jump to,
18 again, still in your report, page 68.

19 A. We've left 40 and 41? 68.

20 Q. Okay. Looking at the bottom of
21 page 68, Dr. Levine, paragraph 78. It states,
22 "Similarly, the American Psychological
23 Association has stated because approach" --

24 A. Sorry.

25 Q. I apologize.

1 Gender Nonconforming People (2015)."

2 So is that lack of consensus that you
3 discuss a justification to categorically ban
4 social transition for children as a treatment
5 for gender dysphoria?

6 MR. KNEPPER: Objection, form.

7 A. By, "Children," you mean 6 and 7
8 year olds?

9 Q. Those for whom medical intervention
10 is not indicated.

11 A. Is that a reason to ban it?

12 Q. Correct, social transition.

13 MR. KNEPPER: Objection, form.

14 A. The reason to -- so let me qualify
15 that. There's a, yes, answer, there's a reason
16 to ban it. And the reason to ban it is both a
17 developmental and an ethical reason. There
18 have been eleven studies of these cross-gender
19 identity children who are not socially
20 transitioned and the vast majority of them
21 de-transition by the time they're mid
22 adolescents or older adolescents. They become
23 homosexual individuals usually or bisexual
24 individuals, but they are cis gender.

25 So if we take a 6-year-old child and

1 A. -- nor you didn't ask me to comment
2 on that.

3 Q. It was related to what you had said
4 before. So this is related but not related to
5 what we just read. So you can put that aside.

6 A. Okay. But your next question was
7 about puberty blocking hormones, which are not
8 being used for 6-year-old's and 7-year-old's --

9 Q. Correct, yes, a separate group of
10 people.

11 A. -- so we're on a different
12 category.

13 Q. Yes.

14 A. Okay. So you asked me if I think
15 puberty blocking hormones should be used on a
16 case-by-case basis?

17 Q. Correct, yes.

18 A. I don't think so.

19 Q. So that is to say, there are no
20 circumstances you would advocate for a total
21 ban on that intervention?

22 MR. KNEPPER: Objection, form.

23 A. Number one, I've never seen a child
24 where that has come up where I thought it was a
25 good idea. In the cases I've seen, it was like

1 a treatment for the mother's pathology, not for
2 the child. And it's like a warning sign, boy,
3 be careful. You see, if you see one case like
4 that, you wonder -- and it's so conspicuous,
5 you wonder in the next case, if the same thing
6 is going on in a more subtle way.

7 Is the child acting out the ambitions of
8 the mother or the father? I just think
9 prudence -- I think considering the child has
10 not gone through puberty or has not gone far
11 into puberty and puberty brings all kind of
12 psychological, physical and social changes to a
13 child and those changes lead to desistance in
14 many, many children, to put them into a state
15 where all their peers are developing physically
16 and they're going to be poirot (phonetic).

17 And then most of those children have
18 social anxiety problems and they avoid -- they
19 don't have friends, right. And this is going
20 to make them even more different than their
21 peers and it's gone to deprive them of the
22 sexualization of their mind and the discovery
23 of masturbation and the discovery of sexual
24 desire for partners, you see. This is only
25 going to increase the child's difference from

1 her peers or his peers and I don't think this
2 is a prudent idea.

3 And if you wanted me to suggest a ban on
4 anything, it would be a ban on using puberty
5 blocking hormones, especially when the
6 evaluation of those children are focused on the
7 gender dysphoria of the child and not on the
8 background of the child and not on what's going
9 on. So I think that's an answer to your
10 question.

11 If we're going to use these drugs, if
12 we're going to use social transformation of
13 children, if we're going to use puberty
14 blocking hormones, it should only be used in a
15 carefully designed protocol. And follow up has
16 to be guaranteed so in one year and in two
17 years and in three years and before we start
18 giving cross-gender hormones we have data --

19 Q. Sorry.

20 A. -- so the answer to your question
21 is, I would consider banning puberty blocking
22 hormones even for children who have been
23 cross-gender identified for four years to give
24 them a chance to desist, which is exactly what
25 the Dutch protocol did, by the way.

1 Q. Sorry. So you just said you would
2 ban -- you would recommend a ban on --

3 A. If --

4 MR. KNEPPER: Objection, form.

5 A. -- look, I'm a doctor. I'm not a
6 policy maker --

7 Q. I understand, yes.

8 A. -- if you ask me my political
9 opinion about, should we ban this, is that a
10 reasonable thing, I think there's a very strong
11 argument for banning puberty blocking hormones.

12 Q. Okay. And, right. So you're here
13 as an expert offering an expert opinion. So
14 are you separating that from -- like are you
15 saying your political views that you would
16 advocate for bans or are you saying your expert
17 opinion you're offering in this case is you
18 would recommend ban?

19 MR. KNEPPER: Objection, form.

20 A. I would recommend ban. To what
21 extent it's from my politics or from my being a
22 parent or from my being a doctor, I don't know.
23 I would recommend we not use puberty blocking
24 hormones.

25 Q. In Claire, in this case that we

1 Answer: "Where we had a healthy mother
2 and father, an intact family who was
3 psychologically informed and who has -- where a
4 child has come out of toddlerhood acting
5 consistently in a gender atypical fashion, and
6 where the parents are not homophobic..."

7 Question: "The parents are not what kind
8 of people?"

9 Answer: "Homophobic."

10 For the 27th time, did I read that
11 correctly? Did I read that correctly?

12 A. Yes.

13 MR. CHARLES: Okay. All right.
14 Let's go ahead and take a break for a few
15 minutes.

16 VIDEOGRAPHER: Off the record 3:20.

17 (Recess taken.)

18 VIDEOGRAPHER: On the record 3:38.

19 BY MR. CHARLES:

20 Q. So, Dr. Levine, before the break,
21 you were talking about 6 and 7 year olds and
22 you mentioned there were eleven studies. Can
23 you identify which eleven studies from your
24 report you're referring to?

25 A. Cantor, the reference Cantor lists

1 the eleven studies and these eleven studies
2 have been done over probably thirty years.

3 Q. Okay. So Cantor was one review of
4 eleven studies?

5 A. Cantor was a review of the eleven
6 studies. I can't list to you the eleven
7 individual studies. The latest one is written
8 by Singh, S-i-n-g-h. It was published in April
9 of 2021, in the Frontiers of Psychiatry. And
10 that perhaps is the most comprehensive of them.
11 And that's the one that confirms -- that's a
12 study of boys and it confirmed that 12.2, I
13 think percentage of them persisted over a
14 thirteen-year period.

15 Q. So that was one -- that was the
16 Singh study that came out. Is that same study
17 mentioned in the Cantor review?

18 A. (Nodding.)

19 Q. Okay. And you said that
20 established that 12.2 percent of prepubertal
21 boys persisted into adolescents? Okay.

22 A. Yes. This harkens back to the
23 ethical issue that I talked about before. You
24 know, if you know that 88 percent of them are
25 going to persist -- desist, why in the world

1 identified 60,000 case reports world wide on
2 the Internet. See Exposito-Campos..." --

3 A. That is an error, by the way.

4 Q. Sorry. Which part of that is an
5 error?

6 A. That, "60,000," is my error. It
7 should say, "16,000."

8 - - - - -

9 (Thereupon, Deposition Exhibit 17,
10 "A Typology of Gender Detransition
11 and Its Implications for Healthcare
12 Providers," Article, was marked for
13 purposes of identification.)

14 - - - - -

15 Q. Okay. So for the record, I'm
16 showing Dr. Levine what has been marked as
17 Exhibit 17. "A Typology of Gender Detransition
18 and Its Implications for Healthcare Providers,"
19 Pablo Exposito-Campos, 2021. Okay. Have you
20 seen this study before, Dr. Levine?

21 A. Yes.

22 Q. Okay. So on page 1 of this report,
23 about halfway through the very first paragraph
24 in the introduction beginning with, "As a
25 consequence." Do you see that there?

1 important to note that this typology does not
2 suggest two clear-cut categories, for a
3 secondary detransition can lead to a primary
4 detransition" -- oh, sorry. Let me start over.
5 Sorry.

6 Okay. Let me start from a different
7 place, Dr. Levine. The second sentence.

8 "In r/detrans" --

9 And there's an HTTP address --

10 A. Okay.

11 Q. Okay. You see that.

12 -- "a subreddit for detransitioners to
13 share their experiences with more than 16,000
14 members, one can find several stories of people
15 who call their transgender status into question
16 after stopping transitioning due to medical
17 complications or feeling dissatisfied with
18 their treatment results"?

19 Do you know what a, "Subreddit," is,
20 Dr. Levine?

21 A. I believe it's just a division of a
22 larger website where people, you know, with
23 similar interests.

24 Q. Okay. Do you understand this
25 sentence to be suggesting that all 16,000 of

1 those members have offered a story of
2 detransition?

3 MR. KNEPPER: Objection, form.

4 A. I think -- I think it may be true
5 that either they have offered a personal story
6 or they're fascinated because of their own
7 considerations of that story. They're thinking
8 about it themselves, which would be in keeping
9 with the idea that even people who have
10 transitioned begin to doubt whether they made a
11 wise decision and they're considering
12 detransition. I'm not so sure it means that
13 all 16,000. I would have no way of
14 ascertaining that. You know, in my worry, I
15 would lean towards most of them are seriously
16 considering or have detransitioned. And in my
17 skepticism, I would say I'm not sure whether
18 it's 15,000 or 12,000 or 8,000.

19 Q. But you have no way to confirm
20 that --

21 A. I have no way.

22 Q. -- if it's all of them or a few of
23 them or three of them?

24 A. You're absolutely right. I have no
25 way of confirming that.

1 where hormones are safe and surgery is a good
2 thing to do. If a person said that, you know,
3 skeptically, I think that would disappoint
4 certain patients, but how it was said and when
5 it was said in response to what would either
6 determine whether the person is engaged with
7 the mental health professional or leaves the
8 mental health professional. You know, all
9 mental health professionals are not created
10 equal.

11 Q. So it sounds like you're saying it
12 could do harm to that patient?

13 MR. KNEPPER: Objection, form.

14 A. No, I'm not saying that. I'm
15 saying it could be disappointing to that
16 person. What that person did with the
17 disappointment may prove harmful just because
18 of that person or it may prove in fact
19 beneficial.

20 Q. Are you satisfied -- let's orient
21 this question around the patients you've seen
22 in the last 12 months. Are you satisfied that
23 those patients -- actually, sorry. Let me
24 start over. Are you satisfied that the
25 patients you have seen historically for whom

1 you provide letters of authorization for
2 hormones give sufficiently informed consent?

3 MR. KNEPPER: Objection, form.

4 A. From my point of view, I did what I
5 could to reach the standard of having the
6 person internalize and think about, digest,
7 dream about and come back and talk to me about
8 it. That's all I can do. I can't guarantee
9 that if I do what I do that it's going to
10 change your mind or help you steer your ship in
11 a slightly different angle --

12 Q. So --

13 A. -- so I would not write a letter of
14 recommendation if I didn't feel like I did my
15 part. And if the person indicated that they
16 couldn't pay attention to me, I wouldn't write
17 the letter.

18 MR. CHARLES: Understood.

19 Okay. John, finished.

20 MR. KNEPPER: You're finished?

21 MR. CHARLES: I mean, barring --

22 MR. KNEPPER: Barring --

23 MR. CHARLES: We can't tell the
24 future.

25 MR. KNEPPER: I wasn't ready for

1 history and current psychiatric diagnosis, it's
2 more complicated than just the internet.

3 But we need to understand who these
4 children are and how they're different from
5 their peers and what we could possibly do to
6 help them to have a better life. I know some
7 of the conversation today was, we'll help them
8 have a better life by giving them puberty
9 blocking hormones, but that doesn't address --
10 I think it has a risk of harming them further.
11 And it doesn't address the comorbid
12 developmental challenges that these children
13 face.

14 And I'm afraid -- and it's controversial,
15 because I don't have the answer. I'm afraid
16 there's a possibility we're making these
17 children have a worse outcome. And until you
18 can demonstrate to me in a very careful
19 controlled study that separates the autistic
20 from the non-autistic, you see? That separates
21 the kids who come from a family that's intact
22 from a family where there's a single parent.
23 Where you can separate the kids who were
24 sexually abused from the kids who were not
25 sexually abused. I'm not sure puberty blocking